UTAH PUBLIC MENTAL HEALTH SYSTEM

PREFERRED PRACTICE GUIDELINES

MA Y 1998

Utah Public Mental Health System
Preferred Practice Guidelines
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Acknowledgments

The Division of Mental Health wishes to thank those who made the effort to define "Preferred Practices" a success:

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Statement of Intent

These practice guidelines are not to be construed to limit in any way, the individualization of treatment, clinician creativity, or the ability of the clinician to provide treatment in the best interests of the client. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These guidelines for practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. It is recognized that optimal outcomes will not always be obtained in treatment.

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Assessment of Children and Youth

OPTIMAL OUTCOME OF ASSESSMENT

The assessment results in the identification of reasons and factors leading to referral, current level of functioning, significant changes in functioning over time, nature and extent of behavioral and subjective difficulties, and individual, family and/or environmental factors, strengths, challenges and resources, which lead to appropriate DSM-1V diagnoses and treatment goals. During this process, a mutually trusting working relationship with the child/youth, family, and significant others is established for continued planning and treatment.

ASSESSMENT PRINCIPLES

1. Assessment of children and youth is an ongoing process. Initially, based upon presenting information, the evaluator should develop an assessment plan including identification of strategies for collecting information and possible assessment instruments to be utilized. These should be adapted as information becomes available. Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s) as well as other pertinent factors should form the basis for all assessment and subsequent treatment.

2. The assessment process will result in an initial diagnosis and development of treatment goals and strategies. As further data is gathered, the diagnosis and subsequent treatment goals and strategies will be reviewed/revised, as appropriate.

3. Whenever a child/adolescent is seen who has a previous psychiatric diagnosis, the assessing clinician should re-evaluate the appropriateness of the diagnosis(es).

4. Diagnosis(es) should be made with adherence to the DSM-IV diagnostic criteria and not based on idiosyncratic/anecdotal impressions. Full use should be made of DSM-IV criteria for co-morbid conditions, atypical presentations, V codes, deferred and provisional diagnoses.

5. Family/care givers are a primary source of information about the child/youth and should be involved in all aspects of the assessment and subsequent treatment planning and implementation.

6. Mental Health staff should encourage and facilitate parents in signing appropriate "release of information" forms in order to gather critical data from multiple individuals and sources significant to the child/youth. This data is essential in forming an accurate picture of the child/youth's functioning. Whenever possible, the clinician should directly contact the primary source of information, i.e., current school teacher for school functioning, family physician for health status, etc.

7. A thorough assessment of a child/youth should include the following areas:
   - Developmental milestones to include receptive and expressive language development
   - Psychiatric and medical history, including vision and hearing problems
   - School functioning and performance including any formal testing conducted by the school
   - Emotional development and temperament
   - Peer relations
   - Family relationships, responsibilities, and perceptions of the child/youth and his/her difficulty and the subsequent impact on the family
   - Strengths, interests, and hobbies
   - Unusual family or environmental circumstances
   - Parental/family medical and psychiatric history and impact on child/youth
   - Substance use
   - Traumatic circumstances including child abuse, domestic violence, family substance abuse
   - Legal involvement
   - Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s) mental status examination, including thought (content and process), perception, mood, level of suicidal risk, affect, memory, judgement, appearance, and orientation.

8. Assessment will be provided in a culturally sensitive and appropriate manner consistent with the unique characteristics of the child and family, taking into consideration factors including, but not limited to: language, socio-economic factors, family and extended family structure, religious practices, geographic location, immediate community, etc. When indicated, the assessor will seek assistance in order to assure that the assessment will be conducted consistent with the language and culture of the child/youth and family.

9. Standardized behavioral assessments such as the Child Adolescent Functional Assessment Scales (CAFAS) and/or Achenbach Child Behavior Checklists (CBCL) for parents, teachers, school-age children or youth may be useful. All evaluation instruments will be selected and administered by appropriately trained personnel in compliance with administration standards provided by their producer(s) as being appropriate for the sex, age, and race of the child/youth. Conclusions derived from any instrument should be made in the context of all information gathered.

10. Depending upon age and developmental factors, the child should be interviewed individually and with the parent(s)/significant others. The setting is critical to the success of the interview and must be sensitive to the need to accommodate for the child's cognitive, language and emotional status. Specific techniques may include interactive play, projective approaches, and direct discussion. Structured observations or other means of seeking information should be utilized. Care should be taken to avoid questions that lead a child to answer in a particular way.

11. The Serious Emotional Disorders (SED) form should be completed.

12. Information about the results of this assessment process, diagnosis(es), and implications for subsequent treatment for the child/youth and family should be shared with the parent(s) or guardian.

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Treatment of Disorders in Children and Youth

OPTIMAL OUTCOME OF TREATMENT

The child/youth attains a level of functioning that is seen as appropriate by the child/youth, primary care-givers, family, therapist, and other support service representatives. The child achieves healthy development and growth, and is better able to manage future episodes of illness.

TREATMENT PRINCIPLES

1. The family/ primary care-giver provides support and nurturance for each child/youth and, as such, should be involved in a working partnership with the mental health professional in all aspects of treatment development, implementation, and evaluation. In instances where children are in state custody and parent's rights have not been terminated, families of origin should be included in treatment planning.

2. Treatment goals and strategies should be collaboratively derived and based on reasons for referral, data collected during the assessment process (per assessment guidelines), and responsive to the needs of the child/youth as she or he functions across daily living environments and situations. Discharge criteria should be addressed at this time.

3. Treatment plans should be individualized considering the following:
    - Cognitive, developmental, and personally differentiating characteristics of the child/youth
    - Unique family characteristics
    - Cultural customs
    - Community expectations
    - Environmental demands, including care giver and school standards

4. Treatment plans should identify indicators of progress to include time-frames and responsibility for data collection and analysis. Progress data should be collected from multiple sources across the settings and environments in which the child/youth functions. This should include response to medication and compliance.

5. Family therapy, including siblings and extended family members, and parent training should be considered in treatment planning.

6. Crisis intervention planning should be considered as part of the overall treatment plan.

7. Services must be frequent enough and of appropriate duration to benefit the child/youth and family. Flexibility will be required in scheduling and in being responsive during emergencies.

8. The setting for treatment should be child/youth and family friendly. The setting should be accessible and not place undue stress upon the family. Treatment in the child/youth's natural environment should be sought whenever appropriate.

9. Wrap-around services should be extended beyond the child/youth to include family members, and may include: collaborative consultation, family therapy, respite care, family support, mentoring, and recreational activities not limited to the mental health center. In areas where available, referrals should be made to parent support organizations.

10. Each treatment plan should identify a contact person for the child/youth and family who will coordinate the treatment within the agency as well as with other service providers.

11. Staff working with children/youth should be competent in specialized skills. Complex treatment issues may benefit from a second opinion. In rural areas where a child/youth specialist is not available, on-going supervision, training, and support should be provided to the generalist practitioner.

12. After-care and follow-up services are a critical component of planning treatment transitions in order to anticipate the natural maturation and developmental processes.

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Disruptive Behavior Disorders in Child and Youth

(Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional/Defiant Disorder, Disruptive Behavior Disorder NOS)

OPTIMAL OUTCOME OF TREATMENT

The child/youth attains a level of functioning in the areas of education, social situations, family relationships, peer relationships, leisure time, and/or legal involvement, as agreed upon by parents/guardian, youth, clinical team and involved others.

ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth.)

1. Children/youth should be assessed at intake for possible danger to self and others:
    - 1.1 Assess for suicide potential since it is as high with these diagnoses as with depression.
    - 1.2 Assess violence potential, including but not limited to: gang involvement, access to weapons, violence towards family members, substance use, etc.

2. Assessment should include the ability to: 1) empathize with others, 2) control impulses, and 3) feel guilt and remorse. Assessment should also address traumatic events such as prolonged separation, sickness, head injury, etc. The mental status exam should be age appropriate. Hallucinations are often missed in youth and should be included in the mental status evaluation. Comments of feeling extremely bored should cue further evaluation for depression.

3. Drug screens should be recommended when substance use is suspected, and when hallucinations are present. Standardized screening tools (such as the Adolescent Substance Abuse Subtle Screening Inventory-SASSI) may be helpful in identifying substance abuse.

4. Assess for co-morbidity with mood disorders, substance abuse, developmental disorders, learning disabilities, communication disorders, intellectual impairment, and psychosis. (Also consider that these illnesses may mimic disruptive disorders. Family history of mental illness may be helpful in this differential diagnosis.) The presence of one disruptive behavior disorder increases the likelihood of other disruptive behavior disorders being present.

5. Care must be taken to accurately distinguish oppositional defiant disorder from conduct disorder. The treatment prognosis is often very different.

6. Standardized behavioral assessments such as the Child Adolescent Functional Assessment Scales (CAFAS) and/or Achenbach Child Behavior Checklists (CBCL) for parents, teachers, school-age children or youth may be useful.

7. Assess the context and severity of the disruptive behavior and settings in which it occurs (home, school, community.) The context includes whether problem behaviors occur when alone or with peers, frequency of behaviors, intent to do harm, and whether actual damage occurred. These are also important prognostic indicators. For conduct disordered youth, prognosis worsens with early onset.

8. Assess the family, including discipline patterns and beliefs; age appropriateness of behavioral expectations for the child; substance abuse and attitudes of family members; marital discord and/or domestic violence; current and past maltreatment (including sexual/physical/emotional abuse and neglect); the child's role in the family, Children/youth with disruptive disorders are more likely to be/have been abused than the general population, and this requires careful evaluation. Also, families with domestic violence have a greater likelihood of children being abused.

TREATMENT GUIDELINES (See Treatment Guidelines for Children and Youth)

1. As these disorders are often manifest in uncooperative and angry behavior, intense negative reactions towards these children/youth are common. Clinical staff have the responsibility to be aware of and manage these reactions, and should seek supervision when appropriate.

2. Families should be informed of serious concerns regarding possible danger to self or others. Legal standards regarding duty to warn also apply.

3. Special skills are needed by families and others involved with children/youth with these conditions. Providing such skills to the family should be emphasized. Therapists may need to teach families how to independently access supportive community resources. All staff should avoid language that blames parents. Collaboratively developed behavior management plans are a critical element of treatment.

4. Family, group, social, and self-management skills development interventions are highly recommended treatment modalities. Individual therapy is generally not effective as the only treatment, especially for conduct disordered youth.

5. Medication may be effective in management of specific symptoms and symptom clusters, especially when other interventions have failed and the child/youth is at risk of placement in a more restrictive environment. Medications are usually effective in assisting ADHD children and youth with school, home, and peer functioning. Psychosocial interventions are generally also necessary.

6. Important elements of treatment include:
   - building on strengths
   - focussing on specific behaviors
   - symptom management and/or control
   - child/youth accountability
   - consideration of multiple environment factors.

7. Wrap-around services such as respite, in-home, or in-school interventions and behavioral aide (trackers, youth proctors, mentors, etc.) are often very useful interventions.

8. Close coordination, including direct contact with the child/youth's teacher(s) is highly recommended. This coordination is important initially, and for ongoing evaluation of treatment progress. Advocacy for services to the child/youth may be needed.

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Mood Disorders in Children and Youth

OPTIMAL OUTCOME OF TREATMENT
The child/youth attains an agreed upon level of functioning; the child/youth and primary care giver(s) learn skills to prevent or manage future episodes of illness. These skills can include increased awareness of mood disorder symptoms, continuation of preventative medication, and changes in behavior and thinking about themselves, their environment, and their future which facilitate health.

ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth) Assessment of children and youth involves gathering data from multiple sources which may include schools, family, caseworkers, and child care providers.

1. Children/youth with mood disorders should be assessed at intake for possible danger to self and others when appropriate, and crisis intervention provided as needed. Families should be informed of serious concerns regarding possible danger to self or others. Age appropriate instruments, such as the Achenbach Child Behavior Checklists (CBCL), may be helpful to aid in the evaluation of symptoms.

2. Children/youth who are SED with a mood disorder should be screened and prioritized for necessary services. In addition to traditional services, others to be considered, depending upon the individual needs of the child and his/her family, may include case management, respite care, and in-home services. Child/youth with multiple agency involvement may also be referred to the local FACT committee or other community resources.

3. Children/Youth with a mood disorder should be referred, as indicated, to a medical provider for evaluation for the presence of general medical conditions contributing to the mood disorder.

TREATMENT GUIDELINES (See Treatment Guidelines for Children/Youth) Appropriate psychotherapy, family and child/youth education, as well as medication management are important factors in the effective treatment of mood disorders.

1. Therapists working with children/youth who are mood disordered should actively involve the family, school, and others as appropriate. Focus should be on collaboratively-developed goals and the use of effective, age appropriate treatment methods for children/youth. Individualized approaches outside the traditional office setting are encouraged when therapeutically indicated. Such services might include respite care, in-home and on-site services, and case management.

2. Education about mood disorders in children and youth and the options for treatment should be provided to children/youth and families. This is a valuable aid to treatment. Therapists should provide families and the child/youth the opportunity to discuss the information provided.

3. Medication is frequently an effective component in the treatment of children and youth with mood disorders. Medication evaluation should be considered for those children/youth whose symptoms meet the diagnostic criteria for a mood disorder. In addition to diagnostic criteria, some indicators are:
    - Suicidality
    - Psychosis
    - Severe disruptive behaviors
    - Marked decrease in academic performance
    - Sense of boredom
    - Withdrawal from friends
    - Increased irritability
    - Obsessional somatic concerns

4. The medical provider is responsible for providing the child/youth and families with information about medication, including potential benefits and side effects for children/youth. Families and the child/youth should be encouraged to ask questions and discuss concerns.

5. When a client misses a scheduled appointment, the intensity and immediacy of outreach should be clinically determined.

6. An assigned staff person should assume primary responsibility for the coordination of treatment between care providers. All providers should work collaboratively 'in the treatment. Each provider assumes responsibility for appropriate documentation of their services.

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Psychotic Disorders in Children and Youth

OPTIMAL OUTCOME OF TREATMENT
The child/youth and family learns to manage the illness through developing an awareness of the illness, and acquires skills to overcome or accommodate to symptom fluctuations. The child/youth develops age appropriate living, educational and social skills, and interacts and functions appropriately within the family. The family experiences a sense of emotionally rewarding interactions and stability while simultaneously accommodating for the child's illness with minimal need for support or treatment.

ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth) All staff should provide services which are perceived as non-threatening and affirming of the child/youth's rights and personhood. The assessment should be provided in a manner which does not attribute blame to families. Staff should provide the services needed with sensitivity and patience with the child/youth and family.

1. While the primary source of information in this diagnosis is the observation of the child/youth, it is important that parents/care givers be consulted during the assessment process. They are a critical source of information. Collateral sources of information may include school, significant others, and care givers.

2. Children/youth with psychotic disorders should be carefully triaged to establish the immediacy of need for center services. This should include evaluation of possible danger to self or others, and need for involuntary hospitalization or out of home placement.

3. Children/youth with Psychotic Disorders should be assessed for the need for a neurological, psychiatric, and medical evaluation.

4. Assessment of the family system is a critical component in determining appropriate treatment.

TREATMENT GUIDELINES (See Treatment Guidelines for Children/Youth)

1. Treatment of the family system is essential with particular emphasis on techniques that will modify any destructive patterns that have developed.

2. Psychoeducational information should be provided for family members. Receptiveness of the family to such information provides additional information as to the family dynamics and should be considered in treatment planning. The family should be helped to the understanding and acceptance that the child's illness will not disappear, but symptoms can be managed and controlled.

3. Family support, including respite services for the primary care giver, are critical areas to be addressed in treatment planning.

    3.1 Respite, as defined in the Mental Health Services Manual: Children's Services Section, is preventative in nature and, therefore, is appropriate for children and youth who are not determined to be "in crisis."

    3.2 Family support in the form of assertive case management should address crisis needs as well as other temporary options, i.e., kinship-care, day treatment, partial hospitalization, therapeutic foster care.

    3.3 Families, Agencies, and Communities Together (FACT) Local Interagency Councils (LIC's) may provide valuable resources.

4. Collaborative exchanges of information from all agencies or individuals involved with the child/youth is essential in evaluating the efficacy of treatment, e.g., parents, care givers, teachers, respite care providers, case managers, etc.

5. Medication is critical in the treatment of psychotic disorders. Medication arrangements should be made in accordance with the child/youth's assessed needs. Medical staff have primary responsibility to obtain informed consent from the parent(s), Legal guardians (See HB 213, Treatment and Commitment of Mentally Ill Children), and periodically review medication with the child/youth and family. Therapists should also review medication use with the child/youth and family and refer concerns to the medical staff as indicated.

    5.1 **Under the provisions of HB 213, Treatment and Commitment of Mentally Ill Children, if either the parent or child disagrees with that treatment, a due process proceeding shall be held in compliance with the procedures established.**

6. Family should be made aware of support groups and other community resources.

7. A crisis plan should be developed for each child and family to address the cyclical nature of this illness.

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Assessment of Adults

OPTIMAL OUTCOME OF ASSESSMENT:

1. A working alliance with the client is initiated.
2. The client is assessed to be best served by the mental health organization and the client is connected with relevant treatment staff; or is facilitated to begin treatment at the agency deemed most appropriate. Immediate safety needs of the client are addressed.
3. Diagnosis is reached using DSM-IV criteria, and immediate treatment goals are negotiated.
4. Historical information and current level of functioning which define the context of the presenting problem is obtained.
5. Individualized treatment planning is initiated.

ASSESSMENT PRINCIPLES:

1. Assessments should be provided in a manner that is sensitive to cultural and individual differences.
2. Reasonable accommodations in keeping with the Americans With Disabilities Act (ADA) requirements should be made for clients with disabilities.
3. The client's description of the presenting problem initiates the assessment. Dealing with the client in an empathetic manner should take priority over information gathering.
4. Whenever an adult is seen who has a previous psychiatric diagnosis, the assessing clinician should re-evaluate the appropriateness of the diagnosis.
5. The context of the presenting symptoms should be gathered/obtained with special attention to the following:
   - When were the symptoms noticed, and under what circumstances? (How long, how often, how severe?) To what degree are the symptoms impairing daily functioning?
   - Are the psychiatric symptoms associated with physical symptoms?
   - Are the symptoms associated with the use of substances, or are substances being used to self-medicate the symptoms? This is best assessed when history taking, and again when the working alliance is fully established.

6. The client's current living circumstance should be assessed including: housing, access to the necessities of living, family involvement, social support, current job status and employment.

7. Relationship history should be assessed, including the ability to establish and sustain satisfying relationships.

8. **The Assessment should include (but is not limited to):**
   - Family of origin and current family information
   - Physical symptoms and medical history, including medications and allergies
   - Impulses to harm self or others
   - Legal history
   - History of personal and family psychiatric treatment
   - Patterns of personal and family alcohol/substance abuse
   - History of traumatic experiences
   - Other personal history including developmental milestones and work history

9. The assessment should include a mental status exam. This exam may be formal or informal, may employ an instrument, or be integrated into the assessment process. The exam should assess for the existence of psychotic symptoms, affect disturbance, anxiety symptoms, and cognitive impairment.

10. Diagnoses should be achieved with adherence to DSM-IV criteria. Diagnoses should not be made in ways that are impressionistic or idiosyncratic. Full use should be made of diagnoses of co-morbid conditions, atypical presentations, V codes, and deferred and provisional diagnoses. Diagnoses should be made on all the DSM-IV Axes. Diagnoses given by previous clinicians should be reassessed for appropriateness and currency.

11. Assessment is an on-going process, therefore, working diagnoses may change and should be continuously evaluated and updated consistent with new information.

12. The Utah Scale for Serious and Persistent Mental Illness (SPMI) should be completed as part of the assessment.

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Treatment of Adults

TREATMENT GUIDELINES

1. The treatment approach used should be appropriate for the individual diagnoses and assessment. Co-morbid conditions should be considered in the development of the overall treatment plan.

2. Within the limits of the resources of the client and the center, the treatment should be provided at the level of intensity indicated by the client's condition and acuity. The treatment setting should represent the level of care that is both the least restrictive setting, and that can provide treatment intensive enough to optimally treat the client's condition. Outpatient visits should vary in frequency and duration, ranging from intensive outpatient treatment (multiple visits per week) to maintenance schedules (monthly, quarterly, or PRN visits). The treatment schedule should be part of the treatment plan.

3. The therapeutic relationship is the foundation of all effective interventions. The therapeutic relationship should be facilitated through the use of empathic methods in addition to structured therapeutic interventions. Therapeutic alliance should be considered in client placement and transfer decisions. When therapeutic alliance is threatened, the therapist should consider clinical supervision. Transfer to another therapist may be indicated.

4. The primary therapist should be aware of the psychiatric medications the client is taking and should communicate problems to the medical staff.

5. The practitioner should practice only in areas in which he/she possesses proper credentialing and/or training, or is developing skills with appropriate supervision.

6. Consideration of individual needs should be primary in selecting the model of intervention to be utilized. This selection should be made in a thoughtful manner taking into consideration the individual assessment. Some psychiatric conditions respond best to specific therapeutic interventions, and efforts should be made to provide those interventions.

7. Treatment should be provided in a manner that is appropriate to the cultural background of the client. When indicated, this may include referral to, or consultation with a practitioner with specific knowledge of the culture of the client.

8. Therapeutic boundaries are the bedrock of effective therapeutic relationships.

8.1 The therapist should establish boundaries which **include** the following:

- Empathy for the client
- Clear and articulated roles and expectations
- Confidentiality of treatment
- Advocacy for the client
- Supervision by third party when indicated

8.2 The therapist should work to establish boundaries that **exclude** the following:

- Any behavior that meets the therapist's needs at the expense of the client
- Exploitation
- Punishing/withholding behaviors of therapist which derive from counter transference issues
- Any romantic or sexual behavior

8.3 In these instances, **clinical consultation should be sought** to insure that clients are not exploited in any way or that the relationship continues to be therapeutic:

- Romantic attraction
- Countertransference conditions (intense emotional reactions)
- Over-involvement
- Social relationships
- Client regression/dependency
- Excessive therapist care-taking

9. The treatment plan should be developed in collaboration with the client in terms easily understood by the client. When appropriate, families and partnering agencies should be included in the treatment planning process. Families should be given the number of the local chapter of the National Alliance for the Mentally ill for information and support.

10. Access to services should be addressed in the treatment planning. The treating agency and clinician should work to remove all barriers possible. Examples may include scheduling accommodations, or provision of transportation or child care.

11. The treatment should work actively towards goal resolution. Goals should be completed or revised actively. Termination from treatment should be worked towards when appropriate, and should be discussed during therapy sessions.

12. In addition to goals for symptom change, the treatment should address environmental interventions that would benefit the client's quality of life. Examples include communicating with landlords, facilitating a change in housing, or working for family accommodations with the client. The therapist should possess a working knowledge of community resources. The therapist should refer the client to case management, as appropriate.

13. When appropriate, psychosocial rehabilitation, which works towards the restoration of social and occupational functioning, should be part of the treatment plan of persons with serious and persistent mental illness.

14. Clinical supervision by colleagues or formal supervisors is always optimal. Clinicians working towards licensure should seek supervision in all aspects of a case. Any therapist should seek supervision in the following instances:

- The client is overwhelming the resources/abilities of the clinician.
- The clinician is required to make decisions about the immediate safety of the client (when time allows for supervision).
- The client has not progressed towards treatment goals and assistance is needed to develop revisions.
- The clinician is experiencing intense "countertransference" feelings of anger, attraction, or responsibility for the client.
- The clinician needs resource assistance from the team.
- The clinician is seeking licensure.

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Anxiety Disorders in Adults

OPTIMAL OUTCOME OF TREATMENT:
The client experiences remission of anxiety symptoms that brought him/her to treatment, or returns to full interpersonal and occupational functioning (as defined by the client) by developing the ability to regulate his/her anxiety symptoms through acquired symptom management skills and psychotherapeutic/ psychopharmacologic support.

ASSESSMENT PRINCIPLES: (See Assessment Guidelines for Adults)

1. The therapist should be aware of the possibility that underlying medical causes may produce anxiety symptoms. Medical evaluation may be indicated to determine that there is no underlying physical problem, i.e., sleep apnea, mitral valve prolapse, thyroid conditions, etc.

2. Clients with anxiety disorders may be at increased risk for suicide. Clients should be assessed for possible danger to self or others and crisis intervention should be provided as needed.

3. Clients with anxiety disorders often self-medicate. Clinicians should assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.

4. Clients with anxiety symptoms should be assessed for depressive features. If the symptoms of depression meet the full criteria for a DSM-IV diagnosis, this diagnosis should also be made.

Post-Traumatic Stress Disorder (PTSD)

1a. The clinician should differentiate between Acute and Chronic PTSD, utilizing DSM IV criteria, to determine treatment approach.

2a. The relative prominence of dissociative features should be assessed. Predominately dissociative symptoms are often an index of severity and may be predictive of chronicity.

3a. The meaning of the traumatic circumstance should be assessed according to the individual's interpretation. Ethnic and cultural factors may be important in this assessment.

4a. Generally, it is not the role of the clinician to seek substantiation of reported trauma. However, in specific cases, seeking substantiation may be effective to rule out factitious disorder or malingering. Clinical indications should be used to determine the necessity of seeking substantiation.

5a. Assessment of pre-morbid functioning and personality traits may be helpful in determining factors that predispose towards chronic effects of trauma.

6a. Co-morbid conditions (such as substance abuse, personality disorders, and mood disorders) are likely to occur with this condition, and should be assessed and diagnosed.

7a. Protective factors, such as social support and self-soothing skills, should be assessed and incorporated into the treatment plan.

TREATMENT PRINCIPLES: (See Treatment Guidelines for Adults)

1. An essential part of treatment is education about the disorder, and helping the client accept the normal experience of anxiety. Educate the client in areas including symptom identification and management.

2. Many clients, due to the discomfort of the anxiety symptoms, become avoidant of anxiety-inducing situations, including therapy. The first priority of treatment is to establish a collaborative relationship which supports the client through the discomfort of coping with their anxiety. It is critical that the first therapeutic contact emphasizes rapport-building and expression of hope.

3. Anxiety disorders such as panic disorders, phobias and obsessive-compulsive disorder are often best treated by the application of a specific cognitive-behavioral component. The therapist should be proficient with such a model or should seek consultation/ referral. Post-traumatic stress disorders often require a more comprehensive treatment approach including supportive therapy, individual and/or group settings, and psychosocial rehabilitation as indicated.

4. Referral for medication evaluation should be considered. Long-term use of anti anxiety medications for chronic forms of anxiety disorder may be appropriate for some clients. Non-addictive medications should be considered.

5. The progression of treatment should emphasize early skin-building success to reduce the likelihood of loss of hope and early termination.

6. Efforts should be made, when appropriate, to recruit significant others to provide increased support and coaching to the client. This should include education concerning the condition and its treatment.

7. Therapy should address the avoidance patterns of the anxious client. Encouragement and specific skills-coaching should work towards the client successfully confronting anxiety inducing situations.

8. Relapse potential may be high with some clients with anxiety disorders. Stress inoculation training (which helps the client anticipate stressors that they win confront, and practice coping skills) may be helpful prior to discharge. The therapist may convey to the client that "booster sessions" can be used to reduce the likelihood of relapse.

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder Acute Type

1a. The goal of treatment of Acute PTSD is to desensitize the client to the traumatic stimuli, which requires rapid exposure therapy over a short course. Low doses of neuroleptics may assist the client in tolerating the distress in the short-term.

Post Traumatic Stress Disorder Chronic Type

2a. The treatment approach should include both skills training and development of the capacity to employ these skills under times of duress.

3a. When working with clients with profound dissociative symptoms, specialized skills or supervision are necessary.

4a. Exposure therapy for PTSD chronic type has a high-risk of producing decompensation and is rarely indicated.

5a. The treatment focus should be on use of supportive psychotherapy which emphasizes the establishment of a strong therapeutic alliance relationship which facilitates the development of self-soothing skills, boundary development, and safety issues. Although trauma issues may be a periodic focus of treatment, therapy aimed at "resolving" the trauma is unlikely to result in direct therapeutic benefit for a client with chronic type PTSD.

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Borderline Personality Disorder

OPTIMAL OUTCOME OF TREATMENT:
The client attains the skills to develop and maintain stability in work, relationships and self--image, particularly through the stormy ages from 20 through 40, avoiding institutionalization, substance abuse, suicide and harm to others.

ASSESSMENT PRINCIPLES: (See Assessment Guidelines for Adults)

1. Assessment of Borderline Personality Disorder requires an alertness to overlapping Axis I and Axis II conditions. DSM-1V criteria must be fully met to make the diagnosis of Borderline Personality Disorder. The diagnosis of Borderline Personality Disorder should be made when the criteria are met. Consultation is often helpful in establishing the diagnosis.

2. The clinician should be alert to the existence of co-morbid Axis I disorders, especially substance abuse and depression. Appropriate treatment should be provided or arranged for these problems. Transient co-morbid symptoms (e.g., psychotic) should be distinguished from those that meet DSM-1V criteria.

TREATMENT PRINCIPLES: (See Treatment Guidelines for Adults)

1. The therapist should have a well-articulated model of treatment for the person with Borderline Personality Disorder which directs treatment beyond a crisis orientation. The therapeutic relationship must model consistent, clear boundaries, and dear explicit goals set in a collaborative manner.

2. Providing education about their disorder empowers clients to better participate in treatments. Over the course of treatment, therapists should educate the client about his/her disorder, including its chronicity, aspects of self-care which affect the course of the disorder, and the prognosis for improvement later in life.

3. With the client, therapists should identify specific short-term goals for each episode of treatment within the course of the chronic disorder. A dear, specific contract should be negotiated with the client.

4. Collaboration is vital to treatment:

   4.1 With team: The intensity of the therapeutic work with this type of client often makes clinical consultation a necessity. The boundaries of the therapeutic relationship should extend beyond the dyad to the treatment team. Neutral, third party clinicians may have the best perspective on recommending changes in the course of treatment.

In some cases, it will be necessary to accept consultation that the therapist has not sought, and to offer consultation when it has not been requested. The role of the team is to provide support to the treating clinician to assist him/her in dealing with the intensity of feelings according to clinical description rather than reactively or pejoratively (Linehan).

4.2 With other providers: Coordination with other agencies/providers may be critical to an effective treatment plan. Therapists should discuss the importance of this collaboration with the client and collaborate when release of information is given. The degree of involvement of significant others in the treatment process needs to be discussed with the client.

4.3 With support staff: During certain phases of the disorder, it may be important to communicate the treatment contract to support staff, including the crisis team and office staff.

5. Treatment needs to encourage optimal functioning. Therapists should not encourage regression, purposefully induce dissociation or revivification of trauma. Exceptions to this guideline should be reviewed with the clinical team.

6. Hospitalization is indicated when there is: 1) imminent danger, 2) lack of available social support, and 3) a history of good response to hospitalization or expected positive response to hospitalization;

-Or-

A history of behavior high in lethal potential with no expectation of rescue or intervention (as opposed to gestures, minor self-injurious behavior or verbal threats).

7. Because hospitalization may encourage decompensation, in general, hospitalization should be as brief as possible to minimize therapeutic dependency and decompensation.

8. Therapists working with borderline clients should emotionally join without enmeshing or over containing the client. This may be evidenced by maintaining similar boundaries as with other clients. The therapist should review exceptions with the clinical supervisor (e.g.: home visits, differences in the amount or frequency of contact, phone calls at home).

9. Therapists working with clients with Borderline Personality Disorder should provide psychoeducation about managing affect (Linehan's Dialectical Behavioral Therapy is a good source, Guilford Press, 1993). Supportive therapy sessions includes assisting the client to manage their affect and therapy disrupting behaviors, e.g., inappropriate anger.

10. Therapists deciding whether to make outreach calls after the client has failed an appointment should consider the following factors: Is the client an active suicide risk? Is there reason to believe their alliance with the therapist has been threatened? Is there any disruption in their primary relationship(s)? These factors may increase risk of harm.

11. Medications may be helpful in targeting specific symptoms.

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Mood Disorders in Adults

OPTIMAL OUTCOME OF TREATMENT
The client attains an agreed upon level of functioning and learns skills to prevent or manage future episodes of illness. These skills can include increased awareness of mood disorder symptoms, continuation of preventative medication, and changes in thinking about oneself, the world, and one's future which facilitate health.

ASSESSMENT GUIDELINES (See Assessment Guidelines for Adults)

1. Clients with mood disorders should be assessed at intake for danger to self (and others when appropriate.) Crisis intervention should be provided as needed. Appropriate quantification achieved through instruments such as the Beck Depression Inventory (BDI or Hamilton Depression Scale may be helpful to evaluate the severity of mood disruption and suicidality.

2. SPMI clients who are affected by a mood disorder should be screened and referred, as appropriate, for case management, psychosocial rehabilitation and/or support services.

3. Clients with mood disorders should be referred to a medical provider, as indicated, for evaluation for general medical conditions which may contribute to the mood disorder.

TREATMENT GUIDELINES (See Treatment Guidelines for Adults)
Psychotherapy, education, and medication are the foundations for effective treatment of mood disorders.

1. Therapists providing psychotherapy with mood disordered clients should use cognitive, interpersonal, or other effective treatment methods and focus on collaborative goals. An individualized treatment plan should be developed with the client and progress should be continuously evaluated. Treatment should be time effective and focused.

2. Client education about his/her illness and treatment options is an essential part of treatment. Clients should be provided information about their illness and have opportunities to discuss this information. Family members and significant others should be included in this process whenever appropriate and possible.

3. Medication is a proven treatment for adult mood disorders. A medication evaluation should be recommended to all clients with recurrent depression, Bipolar Disorder, and clients with symptoms of:
   - A sense of hopelessness, suicidal ideation or behavior
   - Psychotic symptoms, including delusions, hallucinations
   - Severe disturbance in sleep, appetite, weight, concentration, or libido
   - Severe obsessional somatic concerns

4. Clients with a positive response to medication should be advised to continue medication for an appropriate length of time given the age of onset, severity of symptoms, and number of episodes. Medical staff have the primary responsibility to periodically review medication with the client. Therapists should review medication use with the client and refer concerns to the medical staff as indicated.

5. When a client misses a scheduled appointment, outreach should be initiated as clinically determined.

6. An assigned staff person should assume primary responsibility for the coordination of treatment between care providers. All providers should work collaboratively in the treatment. Each provider assumes responsibility for appropriate documentation for the services they provide, e.g., Psychotherapy, Club House Services, Medication Management, etc.

Utah Public Mental Health System
Preferred Practice Guidelines

Psychotic Disorders in Adults

OPTIMAL OUTCOME OF TREATMENT
The client learns to manage his/her own illness, developing awareness of the illness and learning skills which enable him/her to overcome or accommodate symptom fluctuations. The optimal outcome is for the client to live independently and engage in productive activities with minimal need for support or treatment.

ASSESSMENT GUIDELINES (See Assessment Guidelines for Adults) All staff will provide services which are perceived as non-threatening and affirming of the client's rights and personhood. Staff will provide the services needed with extreme sensitivity and patience, especially during periods of confusion and disorientation.

1. Clients with psychotic disorders should be carefully evaluated and prioritized regarding their need for center services. This shall include evaluation of danger to self or others and need for involuntary hospitalization.

2. The assessment should include a determination of current living conditions and circumstances to specifically address housing, health care access, relationships, daily life activities, finances, transportation, etc. If the client has dependent children, appropriate referral for evaluation or services should be made. As client needs are identified, refer to appropriate services, e.g., case management.

3. Clients will be encouraged, where appropriate, to sign a release of information form so that the family and/or support system can be contacted and offered information about the client's psychotic disorder. If a release is signed, the family/support system will be invited to be actively involved in treatment and relapse prevention. Information about psychotic disorders and the Utah Alliance for the Mentally Ill may be provided to the families without a release of information.

4. If there is evidence that the individual is dependent upon and/or under the influence of a chemical substance, an evaluation for the need for medical detoxification should be made. Inquiring about substance abuse is an essential part of the initial assessment. Because substance abuse often coexists with psychotic conditions, therapists will continually assess for substance abuse and encourage appropriate treatment as needed.

TREATMENT GUIDELINES (See Treatment Guidelines for Adults)
"Modem treatment includes not only pharmacotherapy to alter the neurochemical aspects of vulnerability, but also flexible individual and group psychotherapies, psychoeducation, and assertive case management to mitigate the impact of stress; rehabilitation to promote the development of resources; and social, cognitive, and vocational skills and learning strategies to enhance coping capacity" (APA 1995). Particular attention should be given to the stability and sufficiency of the client's living arrangements. All of these services must incorporate the client's life history and experiences, values and interests.

1. The chronic nature of many psychotic disorders may require varying level intensity of services over the course of an individual's lifetime. This will require diligence on the part of the treatment team to keep the client involved in appropriate services.

2. Therapists will assess the client's understanding or interpretation of their symptoms. Therapists will provide or assure that education about the psychotic disorder is available and is complimentary with the client's own personal understanding of his/her symptoms whenever possible. The therapist will assist in providing current information about symptom management.

3. Medication is critical in the treatment of psychotic disorders. Medication arrangements should be made in accordance with the client's assessed needs. Medical staff have primary responsibility to periodically review medication use with the client. Therapists should review medication use and refer concerns to the medical staff as indicated.

4. The therapist will engage the client in relapse prevention. This may include discussion with the client regarding preferences for people to contact, with whom he/she feels the safest, and alternatives to hospitalization in times of crisis to include the use of the Mental Health Advanced Directive ([UCA-62A-12-504] Forms available from the State Division of Mental Health.)

5. A collaborative team approach to treatment is essential. The team includes the client, therapist, case manager, other psychosocial rehabilitation team staff, and medical staff. Involvement of family and other community/social supports is also highly recommended when appropriate. Cooperation, coordination, and communication are critical for good care and treatment.

6. Therapy with clients with psychotic disorders will include assisting the client to address issues of loss, previous treatment experiences, relationship issues, parenting skills, self-image, and depression as appropriate. Therapy need not focus solely on psychotic symptoms unless that is the client's choice.

7. Because of the often unpredictable and/or slow process of recovery, staff will communicate hope to clients, and assess progress by improved quality of life (as measured in family/friend relationships, living situation, work, health status), as well as remission of symptoms.

8. Clients with psychotic disorders will be given appointments which are flexible in duration and frequency which meet the needs of the client.

9. Medical providers are responsible for providing information to the client about medication, including potential benefits and side effects, both short and long term. Medical providers will conduct a yearly assessment for involuntary movement, i.e., AIMS or DISCUS, with all clients receiving neuroleptics for longer than six months.

10. When substance abuse co-exists with a psychotic condition, attention needs to be paid to the treatment of the substance abuse problem. Concurrent treatment provides the most effective approach. Substance abuse treatment should be specifically tailored for the individual with a psychotic disorder and documented in the clinical record.